



Risk-Informed Quality Assurance

NASA Goddard Space Flight Center
Supply Chain Quality Assurance Conference
October 14, 2009

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Office of Safety and Mission Assurance



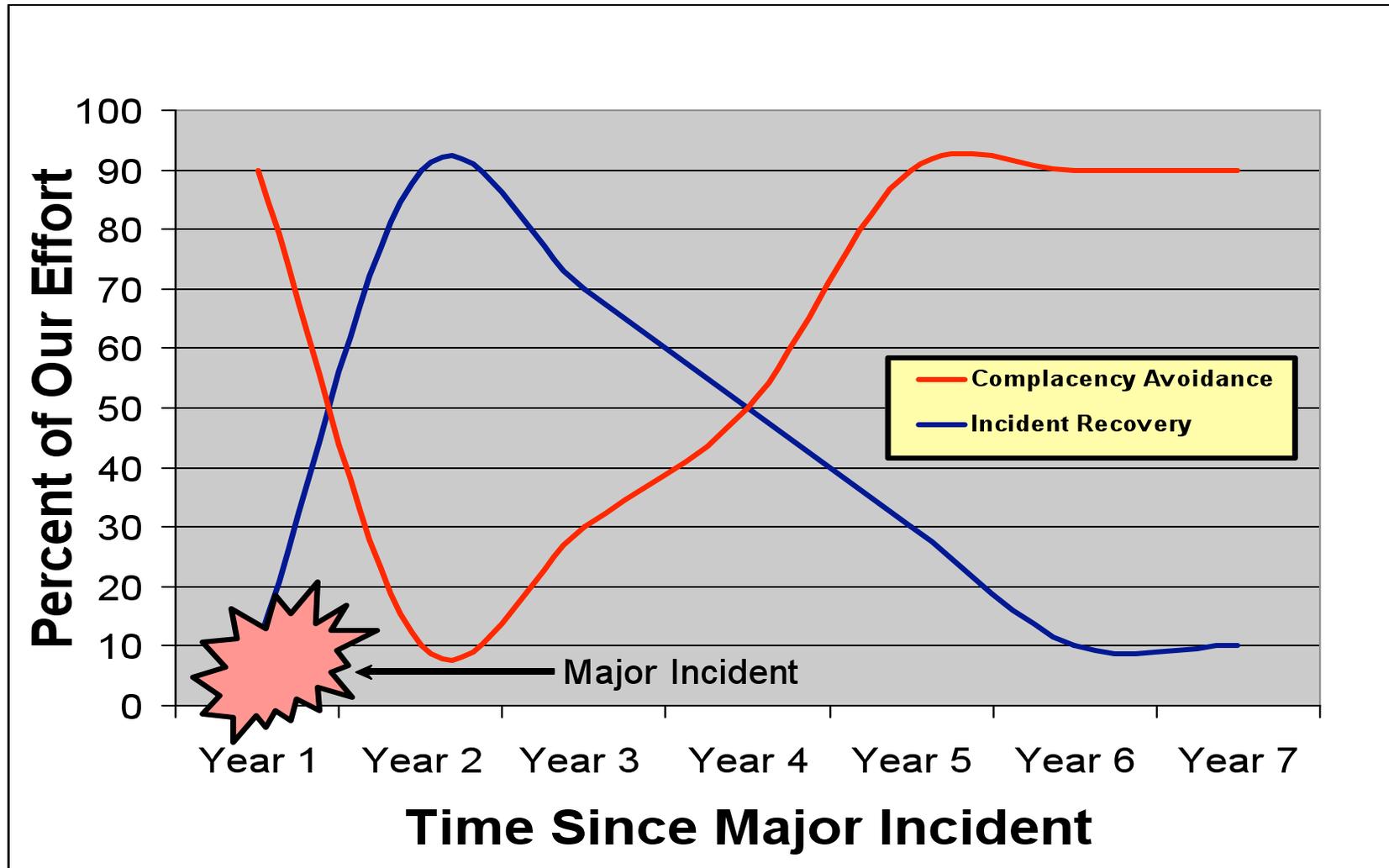
Thought of the Day

The whole problem with the world is that fools and fanatics are always so certain of themselves, but wiser people so full of doubts

Bertrand Russell



The Two Modes of Mishap Prevention





Avoiding Complacency

1. Know the enemy within:

Know your internal quality system weaknesses, and be continually working to remedy them.

2. Know the enemy without:

Know your external quality risks, and be continually working to mitigate them.

3. Focus on risk:

Plan and execute around risk. Don't waste time/resources assuring minimal-risk attributes.

4. Connect the dots:

Think system...know mission and context...



AS9100: 2009

A New (and needed) Focus on Risk

7.1.2 Risk Management

The organization shall establish, implement and maintain a process for managing risk to the achievement of applicable requirements, that includes as appropriate to the organization and the product

- a) *assignment of responsibilities for risk management,*
- b) *definition of risk criteria (e.g., likelihood, consequences, risk acceptance),*
- c) *identification, assessment and communication of risks throughout product realization,*
- d) *identification, implementation and management of actions to mitigate risks that exceed the defined risk acceptance criteria,*
- e) *acceptance of risks remaining after implementation of mitigating actions.*

critical items ... key characteristics ... special requirements



The Risk Iceberg





Risk Management for Exploration

- Known Knowns: (*Systems Engineering, Quality Processes and Program Management*)
 - Disciplined program and mission **management processes and people**
- Known Unknowns: (*Continuous Risk Management*)
 - **Reduce uncertainties** with analysis, ground and flight test
 - Prioritize and manage **residual risk** (including uncertainty) with training, conservative procedures and quality plans
- Unknown Knowns: (*Continuous Process Improvement*)
 - **Communications , Communications, Communications** 
 - Improve data **analysis** tools and techniques (e.g. trending)
- Unknown Unknowns: (*Continuous Research, Test and Eval*)
 - Exercise **Engineering Curiosity**
 - Continuously **challenge assumptions**, models and analyses
 - Be ready for adverse effects (emergency systems)

High Residual Risk* Acceptance at NASA



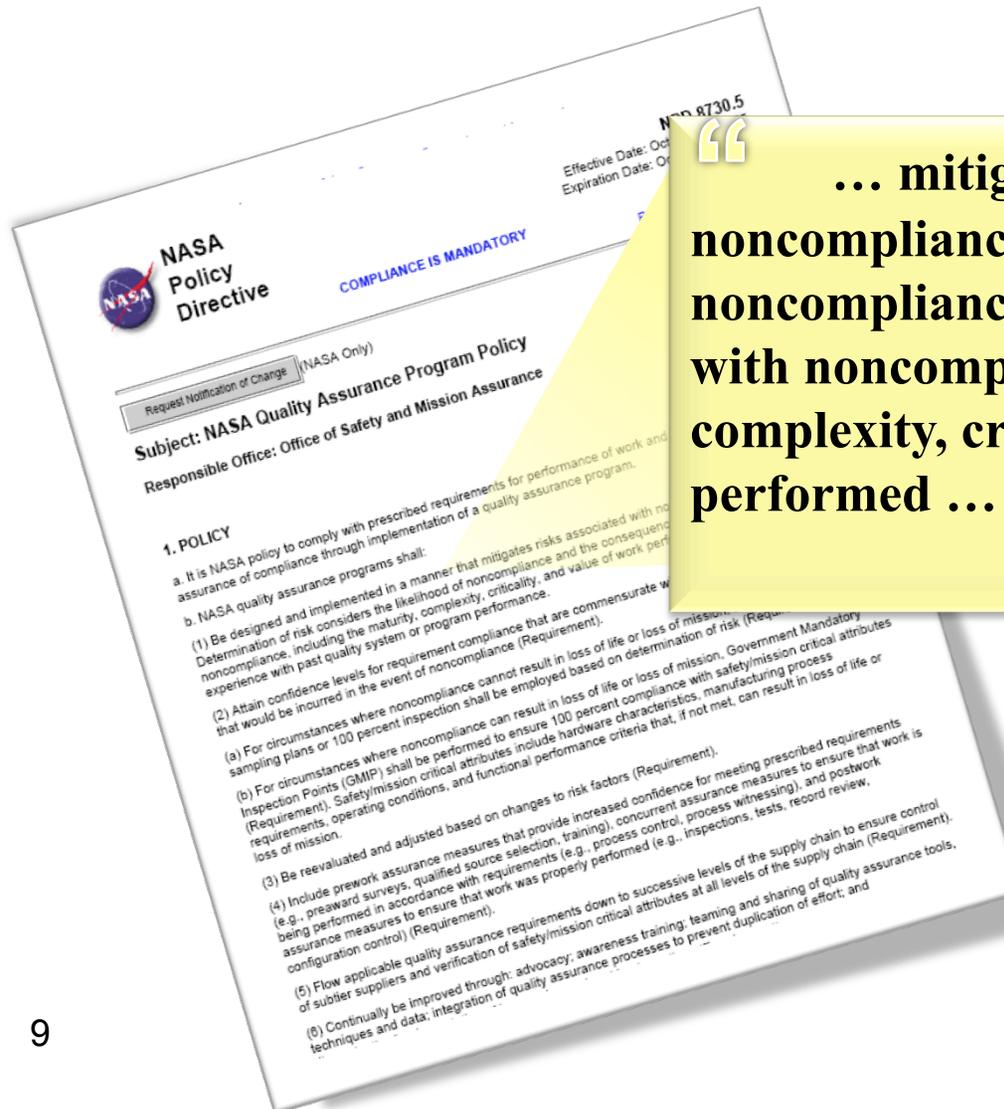
- Tech Authority (relevant tech requirement owner) approves based on technical merit, and
- Safety Tech Authority approves based on risk acceptability, and
- Risk Taker (and supervisory chain of command) volunteers to take the risk, and
- Only then does Program or Ops Manager get to “accept the risk”

*Residual risk is that extra level of risk over and above what is inherent in the design requirements

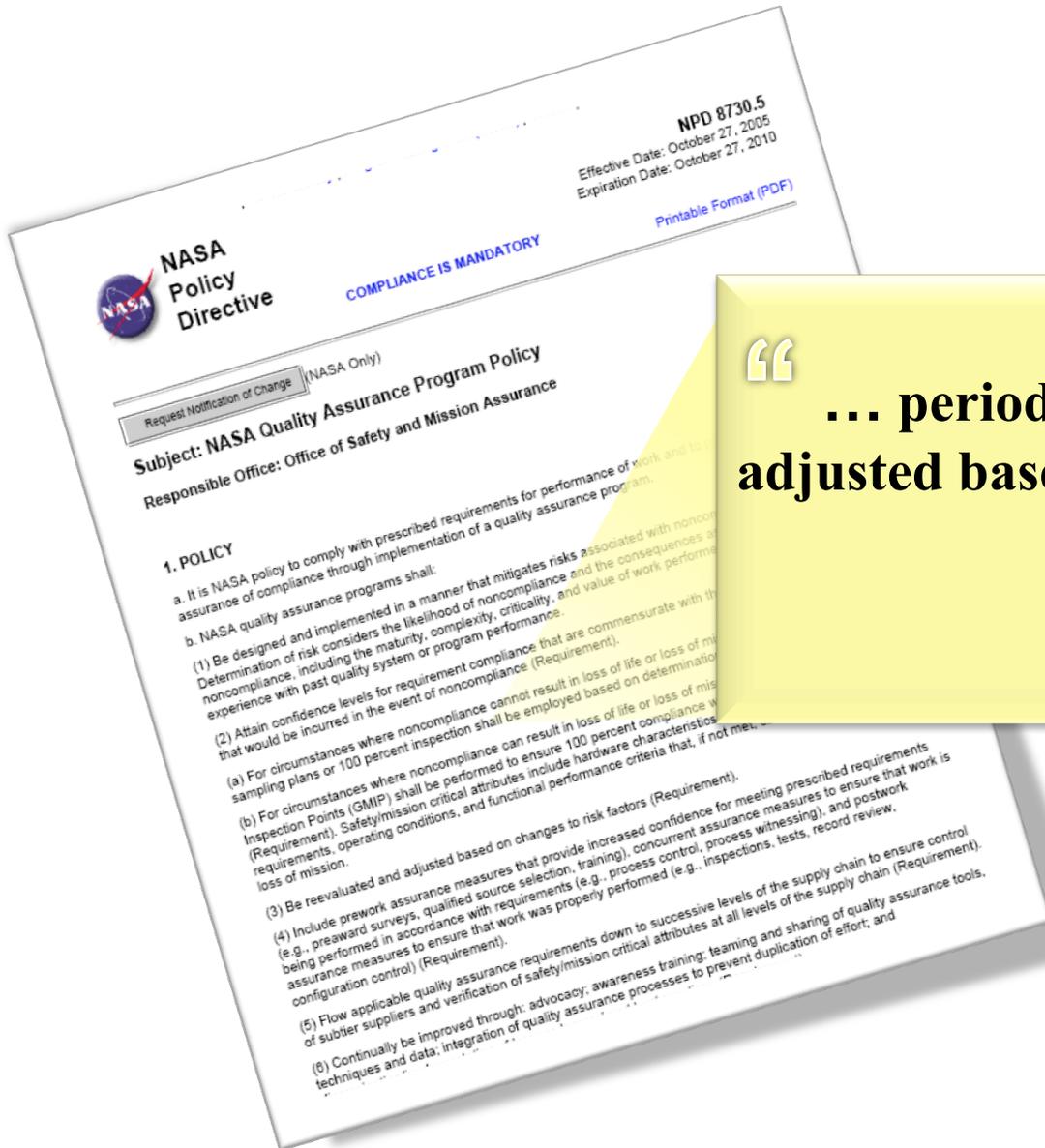


NASA Quality Policy

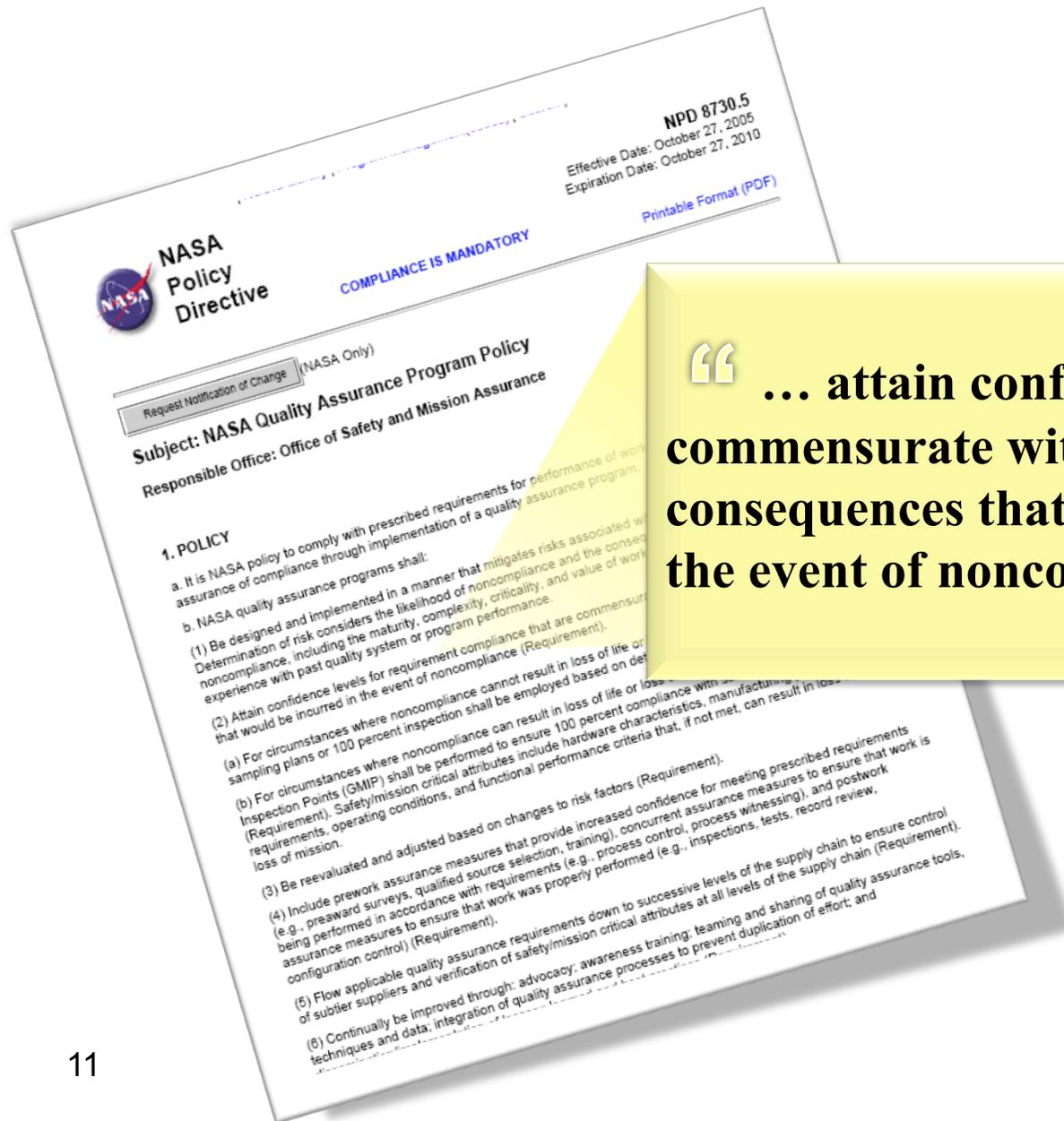
NPD 8730.5



“ ... mitigate risks associated with noncompliance. Risk considers the likelihood of noncompliance and the consequences associated with noncompliance, including the maturity, complexity, criticality, and value of work performed ... ”



“ ... periodically reevaluated and adjusted based on changes to risk factors. ”



“ ... attain confidence levels that are commensurate with the severity of consequences that would be incurred in the event of noncompliance.”



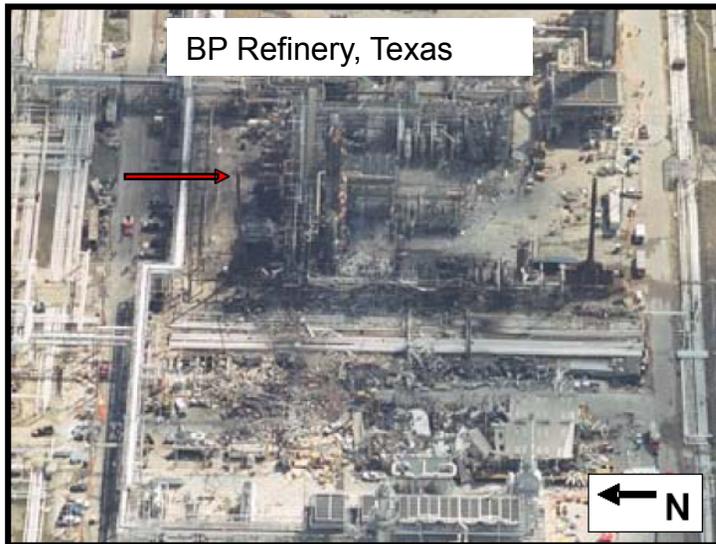
Remember Past Lessons

***No one wants to learn by mistakes, but
we cannot learn enough from
successes to go beyond the state of
the art.***

Henry Petroski

To Engineer is Human

Become a Student of Past Quality System Failures



Vacuum Chamber thought to have been a pressure vessel



Control rod lodged in ceiling of SL-1 reactor building.



USS THRESHER



First in her class

She was fast, quiet, and deep diving.
The leading edge of US Submarine Technology



Apollo 1 Command Module



First in her class

She was larger & far more complex than any previous design.

The leading edge of US Spacecraft Technology



Contributing Causal Factors

- Inadequate Workmanship -

THRESHER

Apollo 1

Improperly brazed pipe joint

“The board found numerous examples in the wiring of poor installation and poor workmanship”.



Poorly brazed pipes led to the electrical shortage that led to the loss of the USS THRESHER.



Figure 2: Wires where the fire was suspected to have started.



Contributing Causal Factors

- Inadequate Fabrication Processes -

THRESHER

Brazed piping joints
exposed to full
submergence
pressure

Apollo 1

Teflon wire coating
could be easily
damaged or
penetrated by abrasion



Contributing Causal Factors

- Ineffective Quality Program -

THRESHER

Portsmouth Naval Shipyard inspectors using newly developed ultrasonic testing techniques identified numerous instances of faulty brazed joints. Many brazed joints on the THRESHER were never UT'd.

Apollo 1

Kennedy Space Center inspectors cited multiple instances of deficient parts, equipment, and workmanship.

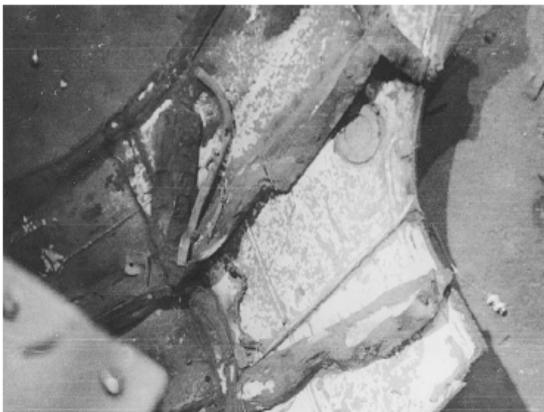


Contributing Causal Factors

- Vulnerable Design -
- Inadequate Emergency Recovery -
- Unforeseen Failure Mode -

THRESHER

- Reactor shutdown
- Impaired access to vital equipment
- Compromised ballast tank blow



Wreckage from the USS THRESHER's sonar dome can be seen on the ocean floor.

Apollo 1

- Single gas atmosphere
- Flammable materials
- Inward opening hatch





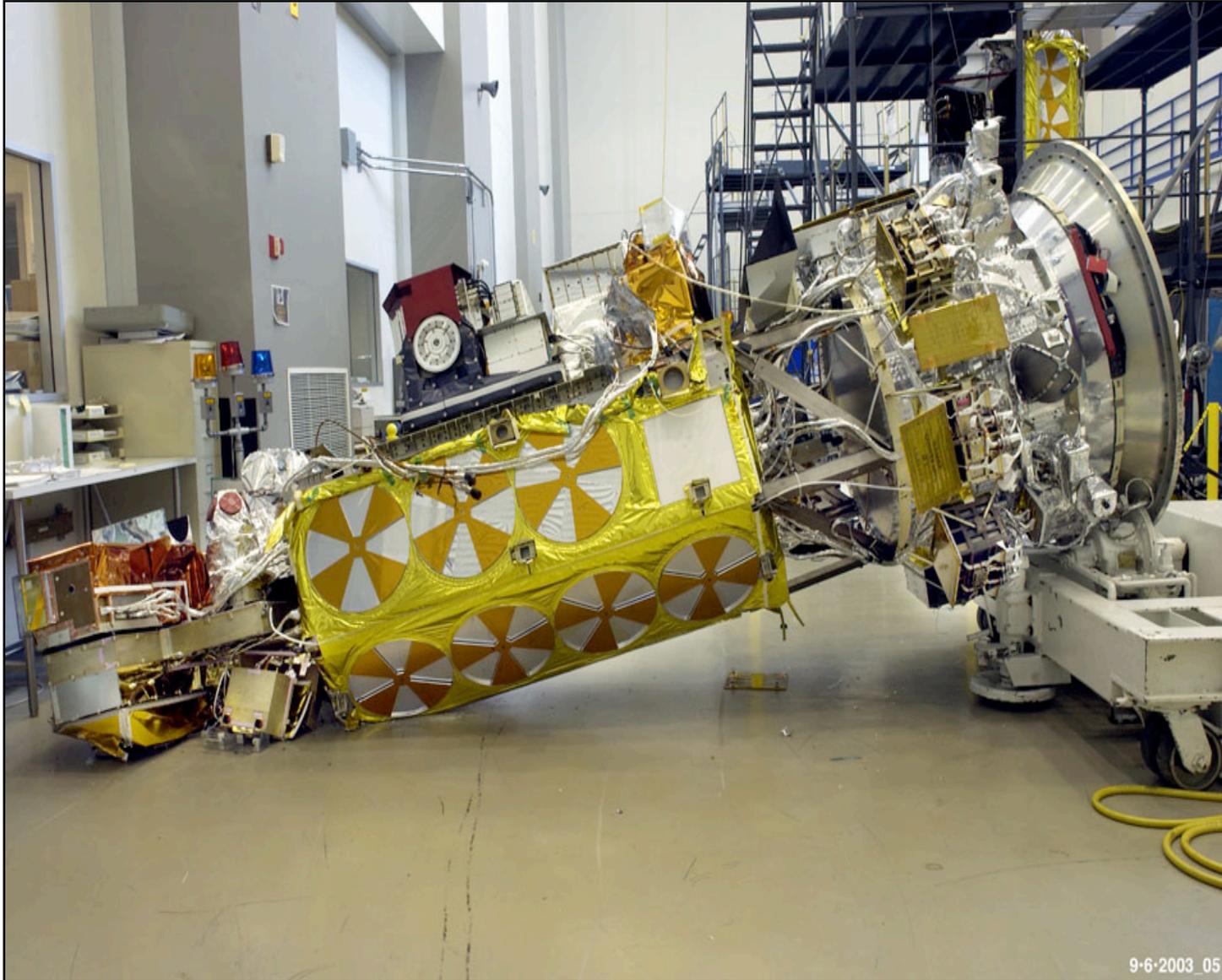
The Enemy Within

- Know your Quality System Weaknesses -

	Documentation - AS9100 Para 4.0	Management Responsibility - AS9100 Para 5.0	Resource Management - AS9100 Para 6.0	Planning/Customer Interface - AS9100 Para 7.1, 7.2	Design - AS9100 Para 7.3	Supply Chain - AS9100 Para 7.4	Production/ Process - AS9100 Para 7.5	Calibration/Metrology - AS9100 Para 7.6	General Quality Assurance - AS9100 Para 8.1	Monitoring/Audit - AS9100 Para 8.2	Control of NCM - AS9100 Para 8.3	Analysis of Data - AS9100 Para 8.4	Corrective and Preventive Action - AS9100 Para 8.5	QA SCORE
BP Oil Refinery Blast	X	X	X	X	X		X	X	X	X	X	X	X	13
Lewis Spins Out of Control		X	X	X	X	X	X			X		X	X	11
USS Thresher				X	X	X	X		X	X				7
Supercritical - SL-1 Reactor	X	X	X		X		X	X			X	X	X	10
US Forrestal in flames	X	X	X	X	X	X	X							8
	3	4	5	4	7	3	8	2	2	3	2	3	3	

Proximate Causes
Underlying Causes
Score
0 = not a contributing cause
1 = underlying cause
2 = Proximate/primary cause

The marked boxes indicate ineffective QMS elements and a failure of quality assurance auditing to identify & correct these shortcomings.



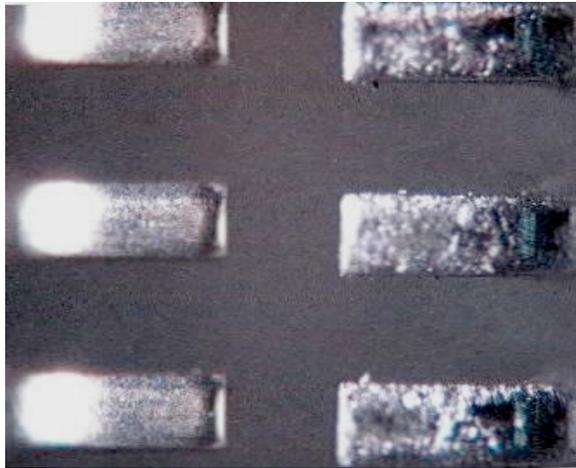
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The Enemy Without

- Counterfeit Parts -



New versus Refurbished leads



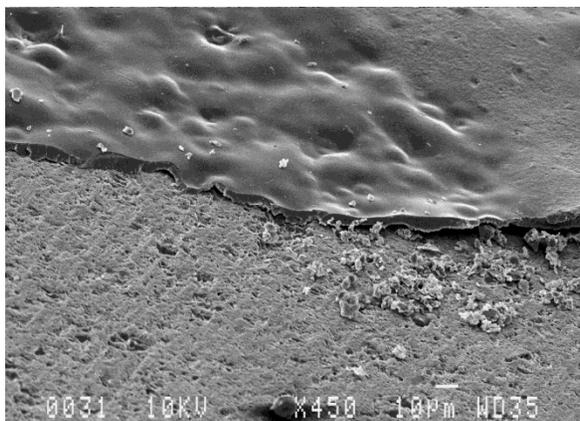
Dual Markings



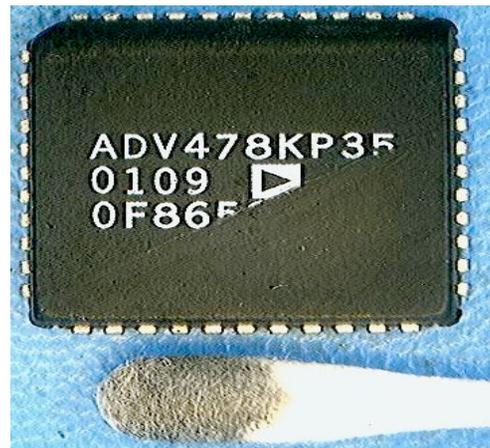
National Semiconductor does not use “ : ” in part numbers



Backtop peeling away. Sand marks evident



Acetone Swipe



Missing Serial Number





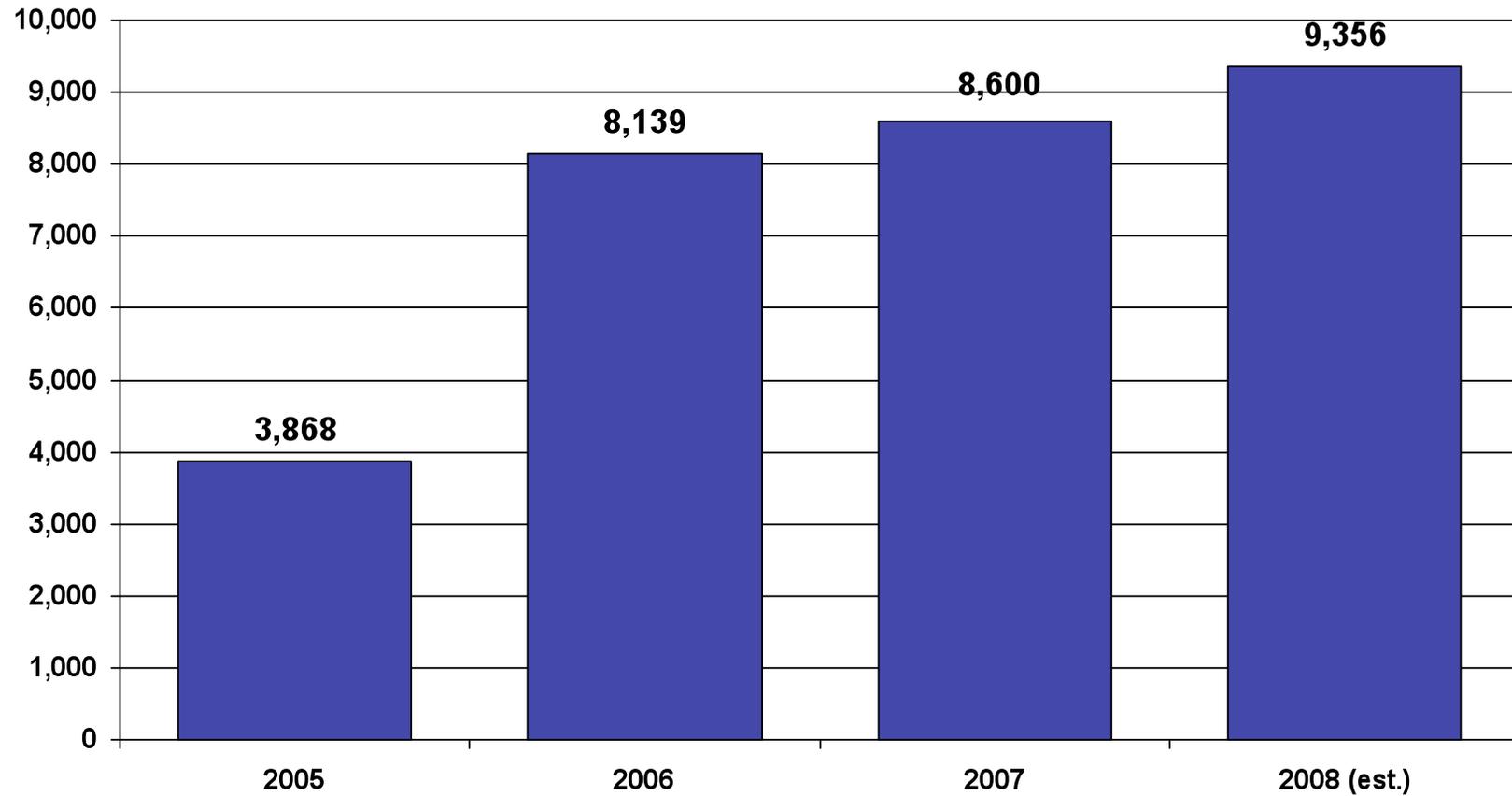
Workers extract plastics from discarded electronics in Guiyu, a few hours' drive northeast of Hong Kong. The city has 5,500 family workshops handling e-waste.
© 2006 The Seattle Times Company



Laborer de-soldering circuit boards over a coal-fired grill. Rock in the box is where boards are hit to remove solder. Pliers are used to pluck off chips which go into various buckets. The boards are then tossed into a pile for open burning. © BAN



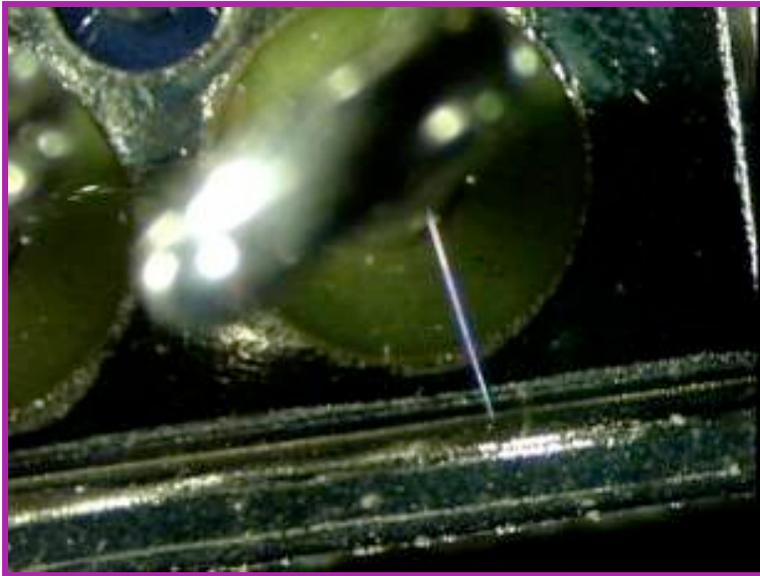
Total Counterfeit Incidents:



U.S. Department of Commerce
March, 2009

The Enemy Without (cont)

- Metal Whiskers -



Tin Whisker on Electromagnetic Relay Shorting Terminal to Case



Zinc Whiskers on Hot Dip Galvanized Steel Pipe



Using Risk to Prioritize

Separate the vital few from the trivial many

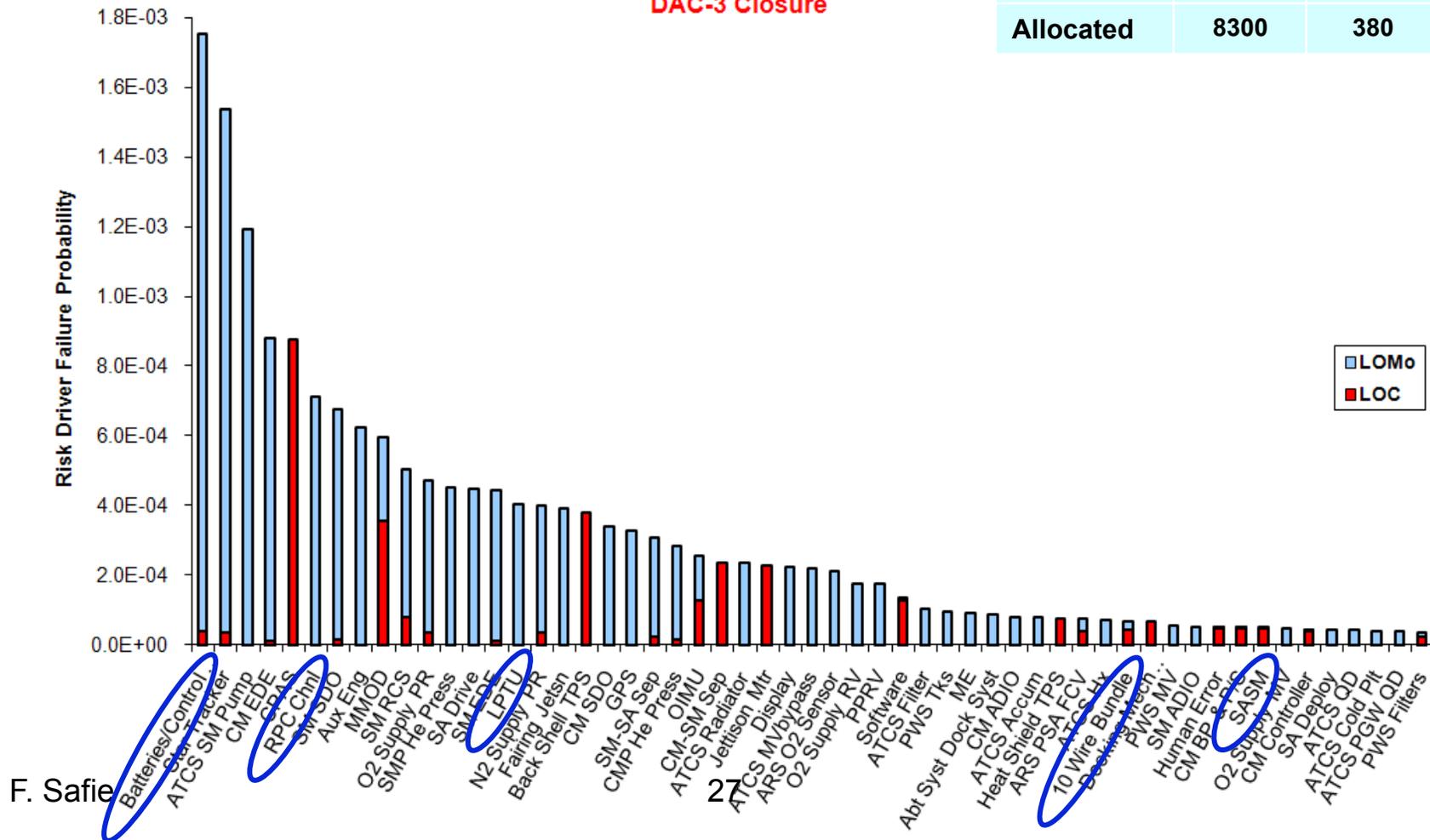
Joseph Juran



606F System Design Top LS Mission Risk Drivers

**Lunar Sortie LOM_T Top Drivers
(95% of Total Risk)**
DAC-3 Closure

LS	LOC	LOM
Predicted	7,748	341
Allocated	8300	380



F. Safie



System Failure Case Studies

SUPERCritical

Background: Two Slew Wits

Procedural Cause:

Underlying Issues:

System Failure Case Studies

INNOVATION PUSHED TOO FAR TOO FAST

Background:

Procedural Cause:

Underlying Issues:

System Failure Case Studies

TUNNEL OF TERROR

Background:

Procedural Cause:

Underlying Issues:

System Failure Case Studies

ALMOST PERFECT

Background: Enhanced Flight

Procedural Cause:

Underlying Issues:

System Failure Case Studies

SUBMARINE DOWN

Background: Faster, Deeper

Procedural Cause:

Underlying Issues:

System Failure Case Studies

FIRE IN THE COCKPIT

Background: Two Smoke Rails

Procedural Cause:

Underlying Issues:

NASA System Safety Case Studies

<http://pbma.nasa.gov/index.php?fuseaction=pbma.main&cid=584>

System Failure Case Studies

LEWIS SPINS OUT OF CONTROL

Background:

Procedural Cause:

Underlying Issues:

System Failure Case Studies

REFINERY ABLAZE — 15 DEAD

Background: Refinery Operations

Procedural Cause:

Underlying Issues:

System Failure Case Studies

TWO RODS DON'T MAKE IT RIGHT

Background:

Procedural Cause:

Underlying Issues:

System Failure Case Studies

NO LEFT TURNS

Background:

Procedural Cause:

Underlying Issues:



Risk Informed, or Risk Averse?

To your own discretion therefore must be left the degree of danger you risk, and the point at which you should decline, only saying we wish you to err on the side of your safety, and to bring back your party safe even if it be with less information.

Thomas Jefferson

Letter to Meriwether Lewis: 1803



GITTERDUNN...

